Request for Plan Termination
Medicare Group Plans

Please print in ink:

Name of Organization: _____ **Group #:** _____

Current Plan: (circle one) Fallon Senior Plan HMO / Fallon Senior Plan PPO / Fallon Companion Care

Member's Last Name: _____, **First Name** _____ **MI** _____

Address: _____ **City:** _____ **Zip:** _____

Telephone #: (_____) _____-_____ **DOB:** ___/___/_____ **Gender:** M or F

Medicare Claim #: (Health Insurance Claim Number) _____-_____-_____ _____

Termination of coverage:

Termination of health insurance coverage for this member will be effective the first day of the month following receipt of an authorized request, unless a specific date up to 3 months after the request is received. Members who have requested termination of coverage must continue to receive all medical care as provided in their Member Handbook/Evidence of Coverage until the effective date for plan termination. Requests for retroactive termination of coverage will be considered on a case by case basis and are subject to CMS approval. The member is responsible to contact the employer group benefits office in advance of the termination date.

Note to Medicare beneficiary:

If this is the first time that you had enrolled into a Medicare Advantage plan, and if you are requesting to terminate coverage within 12 months of your initial effective date of enrollment in a Medicare Advantage plan, then you may be guaranteed issuance of certain Medi-gap coverage. You may contact your state insurance department or counseling agency (1-800-882-2033 or TTY 1-800-872-0166) to get more information about the availability of Medi-gap insurance in your state.

Requested date of termination: _____/_____/_____

Termination Reason:

_____ voluntary
_____ deceased DOD _____/_____/_____
_____ nonpayment
_____ moved out of area
_____ request by group

X_____ _____/_____/_____

Signature of member or signature of authorized representative date

An authorized representative signing on behalf of a member must provide the following information. If not the group benefits administrator, an authorized representative form signed by the member prior to this request must be included with this request

_____ _____

Print full name relationship to member

_____ _____

Address telephone number